AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

NAME: **Christie Andrews**
DOB: _____
SSN: _____

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that if the organization/person(s) that are authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient. The purpose of this authorization is to obtain information relating to a potential lawsuit that I am pursuing.

I extend this authorization to any person or entity who has medical information concerning my physical condition, past, present, or future. The authorization specifically includes, but is not limited to, any doctor who has examined or treated me, and any hospital or other health-care institution where I have been examined or treated. It also applies to present and prior employers and any insurance carrier who may have records of my physical condition. I authorize Tara L. Swafford, and/or any representative of The Swafford Law Firm, to use the health information as stated above.

I hereby authorize you to provide Tara L. Swafford, and/or any representative the Swafford Law Firm, with any and all information you may have, without limitation except for "psychotherapy notes" as specifically defined by the HIPAA Privacy Regulations (45 CFR Parts 160 and 164), regarding any physical or mental condition as revealed by your observation, examination, or treatment, past, present, or future. This includes, but is not limited to, providing copies of or access to all medical records of any type, including any documents or correspondence from other health care providers, except for "psychotherapy notes" as specifically defined by the HIPAA Privacy Regulations.

I hereby authorize my healthcare providers to engage in discussions with Tara L. Swafford, or her representatives regarding my physical or mental condition and treatment or examination. This authorization permits, but does not direct, my healthcare providers to discuss these matters with Ms. Swafford or her representatives. They may or may not engage in discussions with them as they decide.

I understand that this authorization will expire on December 31, 2025 or at the conclusion of the litigation entitled *Christie Andrews v. Tri Star Sports and Entertainment Group, Inc.*, currently pending in the U.S. District Court, Middle District of Tennessee, Case No. 3:21-cv-526. one year from the execution of this document. A copy of this release has the same effect as the original and may be used in lieu of the original. Also, I understand that I may revoke this authorization at any time by notifying Tara L. Swafford, in writing at 321 Billingsly Court, Suite 19, Franklin, Tennessee 37067. I understand that this revocation shall not be effective (1) to the extent that this authorization has already been relied upon, or (2) if the authorization was obtained as a condition for health plan coverage and the health plan has a right to contest the coverage under applicable law.

This release includes, but is not limited to, the following healthcare provider: _____

I understand that I have the right to receive a copy of this authorization after I have signed it.

DATED: _____ _____
SIGNATURE